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**Trinity Christian Counseling**
**Suites 300 and 309**
**117 Cass Avenue**
**Mt. Clemens, MI 48043**
**586-468-0401**
**Fax: 586-463-2389**
**counseling@trinityct.org**
**www.trinityct.org/counseling**

## Informed Consent for Counseling Services

I acknowledge that I am voluntarily seeking treatment and that treatment will be rendered by a professional counseling therapist.

I understand that the successful termination of treatment is determined when the counselor and the client agree that the goals of treatment are achieved. However, I also understand that I am free to discontinue treatment on my own at any time.

After 90 days of inactivity in counseling sessions, a client will be termed inactive.

Print Name_____ Date_____

Signature_____

## Release of information

**All information will be treated confidentially unless there is reason to suspect abuse; where there is a clear threat to do seriously bodily harm to self and/or others; or where mandated by court order.**

Please list of names to whom we are authorized to release information to.

| Name | Date of Birth | Relationship to client | Phone |
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